



Washington Cascade Employers Health Insurance Trust Group Medical Questionnaire

Employer's Name	Industry/SIC Name
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Medical Profile - Employer: For all employees and dependents, answer the following questions to the best of your knowledge (to include proprietors, partners, corporate officers.) Provide full details to all "Yes" answers in the space provided below.

1. Have any claims greater than \$5,000 been paid in the last 12 months?	Yes	No
If "Yes", what is the appropriate dollar amount? \$_____	<input type="checkbox"/>	<input type="checkbox"/>
2. During the next 12 months are there any employees or dependents that are expected to be hospitalized or treated for a medical condition? (including prescription use)?	<input type="checkbox"/>	<input type="checkbox"/>
3. During the last 12 months have any employees or dependents been hospitalized or treated for a serious medical condition? (including prescription use?	<input type="checkbox"/>	<input type="checkbox"/>
Check the appropriate boxes below for all "Yes" answers.		
<input type="checkbox"/> AIDS, Any Immune Disorders	<input type="checkbox"/> Congenital (such as Heart Defects, Down's Syndrome, Autism)	<input type="checkbox"/> Growth Disorders
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Connective Tissue	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Adrenal/Pituitary	<input type="checkbox"/> Digestive, Intestinal or Stomach	<input type="checkbox"/> High Risk Pregnancies
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Infertility
<input type="checkbox"/> Bone/Joint/Prosthetic Device	<input type="checkbox"/> Epilepsy/Seizure Disorders	<input type="checkbox"/> Kidney, Urinary or Bladder
<input type="checkbox"/> Brain, Nervous and Mental	<input type="checkbox"/> Endocrine (such as Diabetes, Lupus, Immune Disorders)	<input type="checkbox"/> Liver
<input type="checkbox"/> Cancer, Tumors, Cyst, Growth	<input type="checkbox"/> Eye/Ear	<input type="checkbox"/> Migraines
<input type="checkbox"/> Central Nervous (such as Cerebral Palsy, MS, MD)		<input type="checkbox"/> Musculoskeletal (such as arthritis, neck, back, knee, etc.)
<input type="checkbox"/> Circulatory (such as High Blood Pressure, Cholesterol, CAD)		<input type="checkbox"/> Neurological
		<input type="checkbox"/> Pancreas
		<input type="checkbox"/> Respiratory Disorders (such as Asthma, COPD, Sleep Apnea, etc.)
		<input type="checkbox"/> Skin Disorders (such as acne, eczema, etc.)
		<input type="checkbox"/> Stroke/Paralysis
		<input type="checkbox"/> Sexually Transmitted Diseases
		<input type="checkbox"/> Transplants (Donor and Recipient)
		<input type="checkbox"/> Other _____
4. Are there any employees currently out or during the next 12 months expected to be out on a disability?	Yes	No
If "Yes", how many? _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Are any employees or dependents currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes", how many? _____		

Provide details to all "Yes" answers. Attach additional sheets if necessary.

Employee or Dependent	Age	Condition/Disorder/Disease	Treatment/Prognosis	Begin Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	Medications	\$ Amount of Prior Claims	Tobacco User
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand this information will be used to determine the medical risk of this group. I, as an Officer of this Company, certify that, to the best of my knowledge the information I have furnished is complete and accurate and includes all enrollees and dependents applying for coverage. I understand that it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. I understand Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Authorized Company Officer Signature	Title	Date (MM/DD/YYYY)
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I attest that I have reviewed the responses to the questions on this Group Medical Questionnaire, and I certify, that to the best of my knowledge the questions have been answered accurately.

Broker Signature	Date (MM/DD/YYYY)
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